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ABSTRACT

This study examined the relationship between six dimensions of parental marital conflict and adolescent health risk behaviors, including substance abuse and sexual activity. Subjects were 151 European American adolescents and 110 Mexican American adolescents, ages 12-15, and their parents. Parents reported on their inter-parental conflict at initial interviews. Adolescents reported on parental conflict, their own primary appraisal of threat and self-blame regarding parental conflict, and their emotional distress. At a 6-month follow-up, adolescents reported on their risk behaviors. Results indicated that for Mexican Americans, three parental conflict dimensions--conflict about the adolescent, conflictual process, and conflict intensity--were related to one or more risk behaviors. For European Americans, four parental conflict dimensions--conflict about the adolescent, conflictual process, conflict resolution, and adolescent involvement in the conflict--were related to one or more risk behaviors. The effects of two parental conflict dimensions, conflict resolution and adolescent involvement, were mediated by primary appraisal and emotional distress. (Author/JPB)

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PARENTAL MARITAL CONFLICT AND ADOLESCENT RISK BEHAVIORS: A COGNITIVE-EMOTIONAL MODEL

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Using a cognitive-emotional model, we examined how six dimensions of parental marital conflict were related to adolescent health risk behaviors, including substance use and sexual activity. Participants were 151 European American adolescents and 110 Mexican American adolescents, ages 12-15, and their parents. At initial individual interviews, parents reported on their interparental conflict. Adolescents reported on parental conflict, their own primary appraisal of threat and self-blame regarding parental conflict, and their emotional distress. At 6-month telephone follow-ups, adolescents reported on their risk behaviors. For Mexican Americans, three parental conflict dimensions -- conflict about the adolescent, conflictual process, and conflict intensity -- were related to one or more risk behaviors. For European Americans, four parental conflict dimensions -- conflict about the adolescent, conflictual process, conflict resolution, and adolescent involvement in the conflict -- were related to one or more risk behaviors. Further, the effects of two parental conflict dimensions, conflict resolution and adolescent involvement, were mediated by primary appraisal and emotional distress, as predicted by our cognitive-emotional model.

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PARENTAL MARITAL CONFLICT AND ADOLESCENT RISK BEHAVIORS: A COGNITIVE-EMOTIONAL MODEL

Parental conflict is an important predictor of children's behavioral and emotional adjustment problems in both intact and divorced families (Emery, 1982; Grych & Fincham, 1990). However, the influence of parental conflict on adolescent health risk behaviors has seldom been examined, although adolescent problem behaviors such as drinking, substance use, and risky sexual behavior can be viewed as the adolescent version of externalizing behavior problems. Based on the cognitive theory of stress and coping (Lazarus & Folkman, 1984) and functional theories of emotion (Bretherton et al, 1986; Campos, Campos & Barrett, 1989), we developed a model to explain how multiple dimensions of marital conflict might influence adolescent emotional adjustment and health risk behaviors.

We hypothesized that more frequent conflict, conflict about the adolescent, poor conflictual process, adolescent involvement in the conflict, more intense conflict, and unresolved conflict would all increase adolescents' primary appraisal of threat and self-blame. We expected that primary appraisal would in turn be related to emotional distress, including anxiety, anger and depression. Finally, we hypothesized that distressed adolescents may subsequently engage in health risk behaviors, such as substance use and unsafe sexual activity, as escape-avoidant attempts to alleviate their distress (Lazarus & Folkman, 1984).

METHOD

Altogether, 303 adolescents ages 12-15, and their parents, were recruited from an HMO. Families were European American (n = 151) or Mexican American (n = 152); all were intact. Adolescents' mean age at baseline was 14.0 years; and 54% were male. Most Mexican American parents were born in Mexico (86%), but most of their adolescents were

born in the U.S. (75%).

Family members participated in individual, face-to-face interviews at baseline. At 6 and 12 months, they participated in individual telephone follow-ups. At baseline, parents and adolescents reported on parental conflict, and adolescents reported on their primary appraisal and emotional distress. At follow-ups, adolescents reported on their risk behaviors.

For marital conflict and primary appraisal, items for scales were adapted from existing measures and developed from focus groups (alphas = .53-.91). Conflict intensity was measured using the Conflict Tactics Scale (Straus, 1979). One variable for each marital conflict dimension was produced by combining family members' scores. Adolescents' emotional distress was measured using the Beck Depression Inventory, the Spielberger State Anxiety scale, and the Spielberger State Anger scale. Risk behaviors included frequency/intensity of alcohol, tobacco and marijuana use, ever used other drugs, and degree of sexual experience. (See Table 1.)

This report focuses on adolescent risk behavior at 6-month follow-up. Analyses included the 261 adolescents (110 Mexican Americans, and all 151 European Americans) whose data were available. Correlations indicated that the only demographic variable related to any risk behavior was adolescent age; accordingly, age was used as a control variable in all subsequent analyses.

RESULTS

For Mexican American adolescents, multiple regression analyses revealed that three of the six parental conflict dimensions -- content, process and intensity -- predicted one or more risk behaviors (tobacco use, marijuana use, other drugs and sexual experience; betas = .21-.23, $p < .05$). Specifically, more parental conflict about the adolescent, father

expressing less negative emotion during conflict, mother being dominating during conflict, and parents engaging in greater interparental physical violence during conflict were all related to higher levels of adolescent risk behaviors during the following 6 months. The three conflict dimensions of frequency, resolution, and adolescent involvement in the conflict did not predict risk behaviors; also, adolescent alcohol use was the only risk behavior not predicted by parental conflict. Because the Mexican American sample was too small to adequately test the entire model (Figure 1), we plan to conduct path analyses when 6-month follow-ups are completed.

For European American adolescents, multiple regression analysis indicated that four of the six parental conflict dimensions -- content, process, conflict resolution, and adolescent involvement -- were related to one or more risk behaviors. Further, path analysis showed that primary appraisal and emotional distress mediated the relationship between two conflict dimensions, conflict resolution and adolescent involvement, and most risk behaviors (Figure 1). Conflictual content (conflict about the adolescent) and conflictual process (including mother expressing negative emotions, mother demanding, and father demanding) also predict risk behaviors; however, their effects are not mediated as hypothesized. Frequency and intensity of conflict failed to predict any risk behavior at 6 months.

DISCUSSION

Our results suggest that several aspects of parental conflict are related to adolescent health risk behaviors, among both Mexican Americans and European Americans. Nearly every dimension of parental conflict, with the exception of conflict frequency, predicts one or more risk behaviors among either Mexican American or European American adolescents.

Further, our findings for European Americans show that our cognitive-emotional

model explains the process by which certain aspects of parental marital conflict influences adolescent risk behaviors. In particular, adolescents who become actively involved in their parents' conflict, or whose parents have poor conflict resolution, tend to appraise the conflict as more threatening and to engage in more self-blame regarding the conflict. Adolescents who make appraisals of greater threat and self-blame also report heightened levels of emotional distress. In turn, emotionally distressed adolescents tend to use more alcohol, tobacco and other drugs, and have more sexual experience.

Thus, some parental conflict dimensions appear to have direct effects on adolescent risk behavior, while the effects of other parental conflict dimensions are mediated by adolescents' primary appraisal and emotional distress, as predicted by our cognitive-emotional model.

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Table 1. Frequencies of adolescent health risk behaviors.

	European Americans (n = 151)	Mexican Americans (n = 110)
Risk Behavior	**M or %**	**M or %**
Ever used alcohol	50%	51%
Ever used tobacco	40%	42%
Ever used marijuana	34%	25%
Ever used another drug	21%	13%
Total substances used	M = 1.45	M = 1.31
No substance	42%	41%
One substance	17%	19%
Two substances	12%	18%
Three substances	15%	15%
Four substances	15%	8%
Sexual experience (most advanced level)	M = 2.22	M = 2.34
No sexual activity	26%	24%
Kissing, lips only	15%	11%
Open-mouth kissing	16%	26%
Breast touching	18%	14%
Genital touching	11%	10%
Oral sex	3%	0%
Vaginal or anal sex	10%	14%

Note: There are no significant differences between the two ethnic groups.

Figure 1. **Cognitive-emotional model predicting risk behaviors among European American adolescents (n = 151).**